CARE 24/7
HEALTHCARE

Care 24/7 Healthcare Limited
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CC5

Continence Assessment Checklist

A: SERVICE USER DETAILS		
Name:	**Date of Birth:**	**GP:**
Aware of problem?	**Assessed by:**	**Date:**

B: CURRENT MAJOR HEALTHCARE PROBLEMS

C: URINARY SYMPTOMS	
Frequency (times per day):	Nocturia (times per night):
Urgency:	Average time can hang on:
Urge Incontinence:	Stress Incontinence:
Passive Incontinence (unaware that it is happening)?	
Nocturnal Enuresis (bedwetting)?	Nights per week:
Dysuria (pain or burning)?	Haematuria?
D: SYMPTOMS OF VOIDING DIFFICULTY	
Hesitancy?	Reduced stream?
Straining to void?	Uses manual expression?
Post-micturition (dribbling)?	
E: INCONTINENCE	
When did it start?	
Any special circumstances at onset?	
Is incontinence improving / static / worsening?	
How often does incontinence occur?	
How much is lost each time:	
If aids or pads are used, what type are they?	
Number used per day:	Number used per night:
Are they effective?	
Type and amount of fluid intake?	
Using fluid restriction?	
Past or recent history of urinary tract infection?	
Other urinary symptoms:	

Additional Information:

Signature: ______________________ Date: ______________________

F: PAST MEDICAL HISTORY	
Major illnesses / operations:	
Parity:	Obstetric complication?
CURRENT MEDICATION:	
Any previous investigation or treatment of incontinence?	
G: BOWELS	
Usual bowel habit:	Constipation?
Laxatives or special diet used:	
Faecal Incontinence?	
H: MOBILITY	
Problems with mobility?	Aid used:
Needs what type of assistance?	
Difficulties in transfer to / onto lavatory?	
Foot problems?	Eyesight?
Manual dexterity problems?	Clothing suitable?
Observe self-toileting and comment on difficulties:	
Problems with personal hygiene and self care?	
I: PSYCHOLOGICAL STATE	
Attitude to incontinence:	
Anxiety?	
Depression?	
Impaired mental abilities?	

ADDITIONAL INFORMATION:

Signature: ______________________________ Date: ________________